Shyam Wuppuluri • A. C. Grayling
Editors

Metaphors and Analogies in Sciences and Humanities

Words and Worlds

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Preface

It is a great thing, indeed, to make proper use of the poetic forms . . . But the greatest thing by far is to be a master of metaphor . . . ordinary words convey only what we know already; it is from metaphor that we can best get hold of something fresh – Aristotle

The fish trap exists because of the fish. Once you've gotten the fish you can forget the trap. The rabbit snare exists because of the rabbit. Once you've gotten the rabbit, you can forget the snare. Words exist because of meaning. Once you've gotten the meaning, you can forget the words. Where can I find a man who has forgotten words so I can talk with him?
– Zhuangzi

Metaphors and analogies occupy a prominent place in our scientific discourses as they do in literature, humanities and at the very level of our thinking itself. They shape our mind, our experiences and our interpersonal/intrapersonal behaviour. Etymology of the word 'metaphor' can be traced to the Greek word μεταφορά (*metapherō*), which is derived from μετά (meta) 'across' and φέρω (pherō) 'to carry'. In our final analysis of things, given the structure of language and cognition, we can always find similarities between dissimilar things and vice versa – and metaphors and analogies that dwell in that space between can either help us shape our understanding of the world in beautiful ways using familiar objects and ideas to convey the concrete graspable aspects of the underlying abstractions or forever derail our understanding of the concepts due to their ambiguities and incongruities and can even bring about socio-political ramifications when one doesn't whet them appropriately. Despite the baggage that comes along with them, metaphors and analogies are (and continue to be) indispensable to our scientific practices and outreach. They promote interdisciplinary thinking and collaboration across domains. Also, metaphors by their nature aren't precise, and one has to add bells and whistles and tinker around with them before fully grasping their contextual meaning. So, the task is to employ and decode them skilfully: being mindful of the dividing line between their use and abuse.

How do metaphors shape the study and practice of science? What role metaphors and analogies play at the level of our cognition and linguistic discourses? How do they help us understand and skilfully deal with our complex socio-political scenarios? Through this highly interdisciplinary volume, we would like to systematically

study the role of metaphors and analogies in (mis)shaping our understanding of the world. Articles within that are systematically categorised into various disciplines not only deal with the notion of metaphors and analogies from a scientifico-philosophical perspective but also from a pragmatic and humanities viewpoint. All authors have attempted to make their articles as readable as possible so that a passionate layperson can easily skim through the book and understand a good deal of it. The book does not claim to address everything there is to the subject, but we hope it will at least open up avenues for readers to further explore the deeper and subtler interrelationships between the role metaphors and analogies play in our daily life.

This book wouldn't have been possible without the collective and kind efforts of authors and those who assisted behind the scenes in producing it: given the unprecedented times at the time of assembling this volume. I can't help but resort to metaphors to thank their kindness chronologically. When I first approached Prof A. C. Grayling with an outline of the volume and set of authors, he not only responded positively but has been there all through: encouraging me and enabling me to happily undertake and successfully complete this otherwise strenuous task. His immense kindness, warmth and optimism are acknowledged herewith. I would also like to thank Prof Otavio Bueno for his support and feedback in the initial stages of the volume. I would also like to thank Prof Edward Witherspoon and Prof Nana Last for their willingness to work on another volume of mine - it has been a pleasure collaborating with them. I am very thankful to Alice Major, Prof Brigitte Nerlich and Prof Claus Emmeche for their kindness and support. In the context of typesetting, I would like to acknowledge the efforts of the typesetting staff for their wonderful editorial support. Much of this work has been done during my Albert-Einstein fellowship, and in that context, I would like to acknowledge the perennial kindness of Prof Susan Neiman, Prof David Shulman and the entire board and staff of Einstein Forum who made my stay very memorable. Last but not the least, I am forever indebted to Thích Nhâ′t Hạnh and Tám Lién Đài for teaching me how to smile and live in the present moment. Smile is a cloud that rains happiness on the garden of our face. May it continue to do so!

Einsteinhaus, Caputh, Germany Shyam Wuppuluri

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Chapter 16
From Words to Worlds. How Metaphors and Language Shape Mental Health

Francesca Brencio

The humanity we all share is more important than the mental illnesses we may not
Elyn R. Sacks

Abstract Through this contribution I aim to show how language and metaphors shape our mental health, and how overcoming a diagnosis-centred approach in favour of a person-centred approach one may be of great help for the healing journey and in the therapeutic context. Starting from a critical reflection on the theoretical principles at the core of current use of psychiatric language, I propose a richer and more complex use of linguistic patterns through a broader consideration of mental phenomena. To reach these goals, this work is divided into three sections: in the first I scrutinise the task of psychiatry, in the second section I explore psychiatric classifications and their language, and in the third part I attempt to elucidate why and how a hermeneutic phenomenologically informed approach to mental health can be beneficial for the diagnosis of mental health issues. This contribution aims to serve as a critical basis for the dialogue among clinicians and philosophers; for mental health professionals, I hope to bring into discussion the use of language in the diagnostic process, the recourse to a third-person approach to describe diseases, and the use of psychopathological vocabulary. For philosophers, to explore the notion of *plurality*, an element that has only tangentially been investigated by philosophy throughout its history, but which is central to the understanding of every form of life, including those who are considered pathological.

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16.1 Preliminary Remarks

This contribution defends the idea that language and metaphors have an impact on our search for meaning in life in a way that can be more or less evident, and as such they may also affect our mental health. Through this contribution I intend to explore the topic of language in the field of mental health, starting from a critical reflection on the theoretical principles at the core of current use of psychiatric language, and then proposing a richer and more complex use of linguistic patterns through a broader consideration of mental phenomena. This essay is divided into three sections: in the first I scrutinise the task of psychiatry, in the second section I explore psychiatric classifications and their language, and in the third part I attempt to elucidate why and how a hermeneutic phenomenologically informed approach to mental health can be beneficial for the diagnosis of mental health issues. I argue that a person-centred approach to mental health, in contrast with a diagnosis-centred approach, is a great help for the healing journey and in the therapeutic context.

The goal of this essay is not an accusatory critique of those sciences involved in the care and treatment of mental health complaints from the perspective of philosophical discourse, but rather it is an attempt to investigate the role of language in the creation of scientific models and their impact on our lives. In this regard, this contribution aims to serve as a critical basis for both clinicians and for philosophers. For clinicians I hope to bring into discussion the use of language in the diagnostic process, the recourse to a third-person approach to describe diseases, and the use of psychopathological vocabulary. I also wish to philosophically explore the notion of *plurality*, an element that has only tangentially been investigated by philosophy throughout its history, but which is central to the understanding of every form of life, including those who are considered pathological. As the title of this article suggests, the movement *from words to worlds* aims at describing what kind of worlds we are able to dwell in, to name, to recognise, and to signify, in particular when we enter into the domain of anomalous mental phenomena. Scientific language is always "theory-landed" as Hilary Putnam says[1] and, as such, its use carries with it the legacy of a certain ontology, which can be more or less explicit.

With these preliminary remarks I will move on to the first part this contribution, which aims to discuss the task of psychiatry.

16.2 The Task of Psychiatry

The relationship between language and diseases is inescapable, both in understanding what psychiatry is about, and moreover how abnormal mental phenomena and experiences can be understood. I begin with the odd question: what is the task of psychiatry? But it is not the only related question. A sequence of further queries

[1] See Putnam, H. (1987). *The Many Faces of Realism*. LaSalle, IL: Open Court.

may also be asked: what does psychiatry aim to describe? How does it understand a disease? How does it classify all the abnormal mental experiences one lives? What kinds of treatment are proposed? How does the treatment happen? If we put all these questions in the right perspective, we see that the task of this medical specialty is not confined to making a diagnosis and treating a disease. It should also encompass other issues and challenges, such as to understand its own nature and epistemological status, and even to provide all the tools necessary for reaching its aims.

Psychiatry is a branch of medicine that is focused on the diagnosis, treatment and prevention of mental, emotional and behavioural disorders.[2] If we read the DSM-5 we find this current definition of mental disorders: "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above".[3] Mental disorders are generically considered as brain diseases and this has contributed to the inclusion of psychiatry in the realm of natural sciences since its object is mainly confined to elements which are considered from the side of physiology: the aetiology of symptoms, signs and syndromes at the core of those behaviours which impact and compromise mental health is considered as biological. However, "the etiopathogenesis of most mental disorders is very complex, involving the interaction of a multiplicity of biological, intrapsychic, interpersonal and sociocultural factors".[4] Despite this, as a branch of medicine, psychiatry is understood mainly as a natural science, and very rarely in a close relationship with human sciences.

The distinction between natural and human sciences may be traced back to the second half of the nineteenth century, when the dispute about what method was considered suitable for these two different branches of knowledge took place. At that time one of the main philosophical problems was to understand how, and to what extent, general theory in social science and history might be useful in explaining the dynamics of human action. Johann Gustav Droysen was the first to introduce the distinction between historical and scientific knowledge, underlying the peculiarities of each branch in relation to the philosophy of history. The main point

[2] According to the definition provided by the American Psychiatric Association (APA).

[3] American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders*, 5th edition. Washington: American Psychiatric Association, p. 20.

[4] Maj, M. (2016). "The need for a conceptual framework in psychiatry acknowledging complexity while avoiding defeatism". In *World Psychiatry* 15:1 - February, p. 2.

was not only to describe a causal explanation as to *why* events happen, but rather *how* to understand this description. At the end of the nineteenth century Wilhelm Dilthey proposed a fundamental distinction grounded on the assumption that human sciences (*Geisteswissenschaften*) are aimed at understanding (*Verstehen*) the nature of human experience, while natural sciences (*Naturwissenschaften*) are devoted to the scientific explanation and clarification (*Erklären*) of nature in general. The main argument for this distinction – the roots of which must be traced back both to Kant's understanding of the abstract ability of the human intellect and to Schleiermacher's consideration of the theory of interpretation – is that while in natural sciences phenomena are explained in terms of linear causality (from cause to effect), in human sciences the process of understanding is mainly articulated on relations not confined to a causal mechanism. The distinction between natural and human sciences was at the core of a second division, the one between explanatory psychology (*erklärende Psychologie*) and descriptive psychology (*beschreibende Psychologie*, later called structural psychology, *Strukturpsychologie*). While explanatory psychology was the study of psychological phenomena from a third-person perspective, descriptive psychology was a discipline aimed at describing how mental processes and experiences may find a common structure in consciousness.[5] Through the works of Franz Brentano, Edmund Husserl and the first generation of phenomenologists, descriptive psychology offers a novel paradigm of understanding experiences and the structure of consciousness, and their relationship with temporality and spatiality, among other things.

This distinction between natural and human sciences has been accepted into medicine, where the aim is to describe how certain phenomena take place in the human body, or in the human brain (to remain in the field of psychiatry). Between the end of the nineteenth century and the beginning of the twentieth century, the legacy of Cartesian ontological dualism was also welcomed into neuroscience, which is epistemically inclined to a form of reductionism whereby experience is always something reducible to the activities of the brain, and the mind is considered to be a product of the brain. In other words, our existence and all its meanings are reducible to an organic substrate which presides over activity, emotion, condition, and experience. The consequences of this dualism are seen in the description of mental disorders, which are considered as brain afflictions following the 'dogma' of the eminent neurologist Wilhelm Griesinger. In this context the work of Karl Jaspers plays a major role. Jaspers acknowledges that the dualistic ontology is a mere abstraction whose aims are not of any help in the understanding of a human being in its totality and bodily existence. He calls this approach "brain mythology", an expression aimed at describing how the physiological approach to the understanding and explication of the mental is simply insufficient to understand

[5] Dilthey, W. (1977). *Ideas Concerning a Descriptive and Analytic Psychology* (1894), In W. Dilthey, *Descriptive Psychology and Historical Understanding*. Springer, Dordrecht, pp. 21–120, https://doi.org/10.1007/978-94-009-9658-8_2

it.[6] Jaspers starts with a critique of the somatic reductionism typical of his time, suggesting that the structure of psychic life cannot be found in the structure of the brain. According to him, even injuries in the brain are not valid findings to prove the alteration of the mind because they can only account for centres of disturbance, not centres of performance. In other words, the mind and mental phenomena are not something the brain can create on its own, disentangled from the joint operation of the body and the environment. This is why Jaspers proposed the introduction of the phenomenological method in the context of psychiatry. Phenomenology was conceived as a method devoted to the description of the structures of conscious, lived experiences according to *how they are experienced*, without the imposition of external explanatory frameworks, providing access to mental phenomena and experiences through a first-person approach. In his monumental *General Psychopathology* Jaspers exhorted us to remember that "the idea of the disease-entity is in truth an idea in Kant's sense of the world". [7]Mental disorders cannot be considered as "disease entities". Primarily psychic events may themselves produce a brain dysfunction, but this is a possibility, not a prerequisite for their understanding. The focus on *what* natural sciences describe needs to be implemented through the understanding of *how* someone is really experiencing something. Compared to other specialties of medicine, psychiatry moved from alienism at the end of the nineteenth century to a science "putatively dedicated to the understanding and management of 'mental afflictions' reconceptualized as 'mental symptoms and disorders'".[8]

The issue about the nature of description in psychiatry was ended by the introduction of DSM in the 1952. At that time DSM contained a glossary of descriptions of diagnostic categories and was the first official manual of mental disorders to focus on clinical use. With the introduction of this diagnostic tool (and its following modifications, editions and revisions), the practice of psychiatry has been "dehumanizing" and reduced to the use of a checklist,[9] a common nomenclature but at the cost of the loss of many fundamental elements, such as the cultural and philosophical dimensions of the concepts used in the description of disorders, the theoretical vocation of the epistemology at the core of the manual, and attention to those elements typical of subjective experience. "We need to be humbler and realize the arbitrary (or "historically contingent") nature of the particular diagnostic categories and criteria that we have. Many of them were decided sitting around a conference table first in Washington University,

[6] See Jaspers, K. (1997), *General psychopathology* (trans: Hoenig, J., Hamilton, M. W.). Baltimore: Johns Hopkins University Press. See also Fuchs, T. (2014), "Brain Mythologies. Jaspers' Critique of Reductionism from a Current Perspective", in T. Fuchs et al. (eds.), *Karl Jaspers' Philosophy and Psychopathology*, Springer: New York, p. 81.

[7] Jaspers, K. (1997), *General psychopathology*, p. 569.

[8] Berrios, G. & Markova I. (2015). "Toward a New Epistemology of Psychiatry". In L. Kirmayer, R. Lemelson, & C. Cummings (Eds.), *Re-Visioning Psychiatry. Cultural Phenomenology, Critical Neuroscience, and Global Mental Health*, Cambridge: Cambridge University Press, p. 45.

[9] Andreasen, N. C. (2006). "DSM and the Death of Phenomenology in America: An Example of Unintended Consequences". In *Schizophrenia Bulletin*, 33 (1), pp. 108–112.

St. Louis, during the creation of the Feighner criteria and later in various hotel rooms during the DSM-III deliberations and sometimes even on the back porch of Robert Spitzer's home in Westchester County, New York".[10] It is precisely for its "historically contingent" nature and atheoretical vocation that the descriptions of mental disorders provided by the DSM or ICD manuals are useful for generalization but completely inadequate to understand the lived experience of people living in a psychopathological world. None of the contemporary diagnostic statistic manuals offer a descriptive or theoretical account of those themes which are central to the understating of mental experiences or phenomena. Topics such as the nature of consciousness, the structures of experience, embodiment, disruptions of bodily feelings or changes in atmosphere are not taken into account in providing descriptive guidelines for understanding how it is to live in a psychopathological world. "This conceptual void makes it difficult, if not impossible, to conceptualize the qualities and vicissitudes of subjective life or to envision links and relations (including causal relations) between various mental states and contents".[11] This leads me to a brief discussion about the nature of classification systems in psychiatry, a very rich and complex theme.[12]

16.3 Psychiatric Classifications: Not Only a Matter of Language

The criteria of psychiatric classification systems are more rooted in philosophy than is commonly recognised. They also deal with a pragmatic need: at the end of the 1960s the World Health Organization launched a series of international collaborative studies to establish a science of psychiatry grounded on common diagnostic principles.[13] Over time, it emerged that the American and British ways of making diagnoses were very different and it was very hard to find a general diagnostic agreement among clinicians, mainly due to variations in diagnostic habits. This sense of difficulty was amplified by the emergence of biological research. "The solution to this crisis was to embrace a positivist-behaviourist epistemology, usually called operationalism",[14] which is grounded on some fundamental ideas of logical

[10] Parnas, J., Sass, L. (2008). Varieties of "Phenomenology". On Description, Understanding, and Explanation in Psychiatry. In Kendler K., Parnas, J. (eds.) *Philsophical issues in psychiatry. Explanation, Phenomenology and Nosology*. Baltimore: Johns Hopkins University Press, p. 240.

[11] Parnas, J., Sass, L. (2008). Varieties of "Phenomenology". On Description, Understanding, and Explanation in Psychiatry, p. 249.

[12] See Maj, M., Gaebel, W., López-Ibor, J. J., Sartorius, N. (eds.), (2002) *Psychiatric Diagnosis and Classification*, Chichester: John Wiley & Sons.

[13] Parnas, J., Sass, L. (2008). Varieties of "Phenomenology". On Description, Understanding, and Explanation in Psychiatry, p. 245.

[14] Parnas, J., Sass, L. (2008). Varieties of "Phenomenology". On Description, Understanding, and Explanation in Psychiatry, p. 245.

positivism, progressively flowing into physicalism. Operationalism impacted, and still impacts, psychiatric description, where, for example, there is no room left for patients' first-person accounts of their experiences. One consequence among many others of the use of operationalism is that every reference to metaphysics or ontology was, and still is, deleted and every subjective experience is replaced with physical laws. "Following the operationalism processes, descriptions of mental or subjective phenomena should be cast at the "lowest possible level of inference"—that is, ideally in external behavioral description, or else in simple lay language".[15] In psychiatry, these operationalized criteria have become very influential but little examined.[16] These criteria have silenced any debate about the nature of description or descriptive concepts, "perhaps even viewing such topics as embarrassing or shameful vestiges of a preoperational era that was readily equated with prescientific psychiatry".[17]

Preventing the space for any theoretical discussion about descriptions of subjectivity, classification in psychiatry proceeded only through generalizations about mental disorders. These generalizations are useful when they can be applied to certain conditions, but they may be less useful when the conditions change: "this kind of heterogeneity is often considered to be a flaw in psychiatric nosology, but in fact it may accurately signal inherent complexity".[18] The category of mental disorder encompasses a collection of conditions so heterogeneous "that few, if any, useful generalizations can be drawn about mental disorders as a whole".[19] Operationalism and generalizations are at the core of classifications and, while generalizations may be useful to group conditions, operationalism leads to an increased level of inaccuracy. My suggestion is that the notion of 'utility' applied to a given diagnosis may differ from the same notion given to a certain system of classification. In their daily practice, clinicians use DSM-5 or ICD10 as lists of coding systems. "The point of this critique is not to say that we should abandon striving for clear definitions and for reliability of 'technical terms'. What we should abandon, rather, is the illusory, deceptive, and ultimately counterproductive simplicity of operationalism to strive, instead, for a more adequate, even though more complex and demanding, conceptual framework for the science of psychopathology".[20]

[15] Parnas, J., Sass, L. (2008). Varieties of "Phenomenology". On Description, Understanding, and Explanation in Psychiatry, p. 247.

[16] Parnas, J., Sass, L. (2008). Varieties of "Phenomenology". On Description, Understanding, and Explanation in Psychiatry, p. 240

[17] Parnas, J., Sass, L. (2008). Varieties of "Phenomenology". On Description, Understanding, and Explanation in Psychiatry, p. 243.

[18] Zachar, P. (2008). Psychiatry, Scientific Laws, and Realism about Entities, in In Kendler K., Parnas, J. (eds.) *Philsophical issues in psychiatry. Explanation, Phenomenology and Nosology*. Baltimore: Johns Hopkins University Press, p. 44.

[19] Zachar, P. (2008). Psychiatry, Scientific Laws, and Realism about Entities, p. 44.

[20] Parnas, J., Sass, L. (2008). Varieties of "Phenomenology". On Description, Understanding, and Explanation in Psychiatry, p. 249.

The criticisms of operationalism face another important issue: the issue of validity required by a diagnosis. Rooted in the domain of logic and grounded on the principle of coherence between formal and material validity, the shift from this field of knowledge to psychiatry and clinical psychology is very complicated. Reliability and validity, considered at the end of the nineteenth century as synonyms, were introduced to measure inferred psychological attributes. Only later, were they used to distinguish between measuring a psychological attribute consistently (reliability) from measuring it accurately (validity).[21] The problem was, and to a certain extent still is, how to use a category thought to measure theoretical constructs, whereas in psychiatry what is required is to confirm a disorder or not. In the 1950s the concept of diagnostic validity was introduced "to describe the research programs that nosologically oriented psychiatrists were already conducting",[22] facilitating the path to a concept of validity as confirming theory-based predictions.[23] "Another factor influencing the establishment of a psychiatric research program on diagnostic validity was the emphasis in the 1970s placed on the evaluation of reliability as it was assessed statistically by psychologists. The Washington University group's operationalization of diagnostic constructs (called the Feighner criteria) and Columbia University psychiatrist Robert Spitzer's advocacy of measuring reliability using Cohen's kappa culminated in the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 (. . .). Once the psychologists' more scientific approach to reliability was implemented in psychiatry, the reliability–validity distinction came for free, and with it came the notion that securing validity is the next task".[24]

I will deploy these arguments to show how the issue of language used in diagnostic manuals is strictly tied with the epistemological and methodological problems described above. These are mainly grounded on philosophical presuppositions and different ontologies, which are not usually recognised or taken into account by clinicians in their daily practices. It is correct to say that many epistemological choices which guide current systems of diagnosis (and their history) are fundamentally philosophical issues, despite the efforts made in the last 45 years to exclude theoretical principles from every system of diagnostic classification. The problem of names of illnesses is not merely a problem of language, but also a problem of philosophical concepts and socio-cultural values at the core of contemporary diagnostic systems,[25] a matter strictly related to the problem of classification of diseases.

[21] Zachar, P., Jablensky, A., (2015) The concept of validation in psychiatry and psychology. In Zachar, P., Stoyanov, D., Aragona, M., Jablenski, A. (eds.) (2015). *Alternative perspectives on psychiatric validation: DSM, ICD, RDoC, and beyond*. Oxford: Oxford University Press, p. 3.

[22] Zachar, P., Jablensky, A., (2015) The concept of validation in psychiatry and psychology, p. 5.

[23] Zachar, P., Jablensky, A., (2015) The concept of validation in psychiatry and psychology, p. 6.

[24] Zachar, P., Jablensky, A., (2015) The concept of validation in psychiatry and psychology, p. 6.

[25] See Brencio, F., Bauer, P. R. (2020), "Words matter. A hermeneutical-phenomenological account to mental health". In *Phenomenology and Mind*, 18, 2020, pp. 68–77, doi: https://doi.org/10.17454/pam-1805

At the core of the psychiatric enterprise there is an effort to describe and treat abnormal or disordered experiences and expressions. The first level of description is defined as *phenotypic*, pertaining to what is directly visible or observable,[26] or as *phenomenal*, pertaining to what is manifest or given in a conscious experience. From a phenotypic description, it is possible to identify "signs" and "symptoms," and aggregate these phenotypes into classes relevant to diagnostic categories. The distinction between signs and symptoms was introduced into medical sciences to stress the objective and subjective manifestation and perception of a disease. Through its power to declare which symptoms exist or are important enough to be the focus of attention, psychiatric description focuses on the targets of scientific activity and influences the treatments that are developed and offered to patients.[27] The problem of the names of mental disorders may be investigated from four different perspectives. On one hand, we find a nominalism which suggests that categories like psychiatric disorders are not real, but rather, entirely human creations. On the other hand, we find realism: psychiatric disorders are clear and distinct, real things out there in the world for us to discover. One consequence of such an approach is the problem of reification. The mistake of reification is not in believing that entities such as depression are real, but rather it is in "believing that the entities that are useful in a nosology are more fine grained than they are (that is, they literally represent what depression is). It is a "fundamental" misunderstanding even to believe that they should".[28]A third account of the relationship between names and phenomena is offered by hybrid positions that suggest psychiatric disorders are influenced by both real things in the world and also by cultural, social and economic factors.[29] The final account is offered by pragmatism: the goal is to avoid metaphysical debates about the true nature of psychiatric illnesses and to design a system that relates to treatment response and/or reflects neurobiological or genetic risk factors.[30]

The names of diseases have a profound impact on people's lives. A psychiatric diagnosis can cleave one's life into a distinct "before" and "after" and this division can affect one's sense of meaning in life. In this context, where clinical and existential meanings diverge, and personal circumstances are irrevocably altered, an urgent need arises to recover a sense of coherence. Diagnosis is a medical concept which includes both the process of identifying a disease and the designation of that disease, through an accurate series of investigations and observations. Making a

[26] In contrast to the "invisible" genotypic or endophenotypic level.

[27] Parnas, J., Sass, L. (2008). Varieties of "Phenomenology". On Description, Understanding, and Explanation in Psychiatry, p. 239 and p. 243.

[28] Zachar, P. (2008). Psychiatry, Scientific Laws, and Realism about Entities, p. 46.

[29] Kendler, K. (2012). Introduction. In Kendler, K., Parnas, J. *Philosophical Issues in Psychiatry II. Nosology*. Oxford: Oxford University Press. p. XIV.

[30] Kendler, K. (2012). Introduction, p. XIV.

diagnosis means that the nature of the disease has been ascertained.[31] In psychiatric practice, diagnosis "is (or should be) only one step in the process that leads to the formulation of the management plan and of prognosis. The other step is (or should be) the further characterization of the individual case with respect to a series of additional variables. This second step is at least as important as "diagnosis" in the management of choices and the prediction of outcomes".[32] However, as a matter of fact, this second moment is largely ignored and the information conveyed by diagnosis is in itself insufficient for therapeutic and prognostic purposes. Therefore, it seems that a gap be can be identified in the context of the modern understanding of psychiatric diagnosis and treatment, between the medicalised classifications (or nomenclatures) and the more nuanced complexity of human suffering witnessed in practice. The latter being one element among many others of the fundamental ontological constitution of humans.

16.4 From Words to Worlds: A Person-Centre Approach to Mental Health

In this last part I argue that a hermeneutic phenomenologically informed approach to mental health can be beneficial for the diagnosis of mental health issues and lead to a person-centred approach to mental health in contrast with a diagnosis-centred approach. In order to achieve this aim, I want to trace the use of those words which are normally employed to label our experience or condition of non well-being.

Disease, sickness and illness are words that we commonly use to mean an unbalanced condition in the "functioning" of a person. However, if we scrutinise their meanings in detail, we notice that "disease is a pathological process, most often physical. The quality which identifies disease is some deviation from a biological norm. There is an objectivity about disease which doctors are able to see, touch, measure, smell. Diseases are valued as the central facts in the medical view".[33] By contrast, "sickness is the external and public mode of unhealth. Sickness is a social role, a status, a negotiated position in the world".[34] "Illness is an experience of unhealth which is entirely personal, interior to the person of the patient. Often it accompanies disease, but the disease may be undeclared".[35] To summarise, we can say that disease is the pathological process, a deviation from a biological norm, sickness is the condition negotiated with society, and illness is

[31] See Moncrieff, J. (2010). "Psychiatric diagnosis as a political device". In *Social Theory & Health*, 8(4), pp. 370–382. https://doi.org/10.1057/sth.2009.11

[32] Maj, M. (2018). "Why the clinical utility of diagnostic categories in psychiatry is intrinsically limited and how we can use new approaches to complement them". In *World Psychiatry*, 17, 2, pp. 121.

[33] Marinker, M. (1975). "Why make people patients?". In *Journal of Medical Ethics*, I, p. 82.

[34] Marinker, M. (1975). "Why make people patients?". p. 82.

[35] Marinker, M. (1975). "Why make people patients?". p. 83.

the patient's experience of her health.[36] Outside the spectrum of these definitions is the consideration of suffering itself as an embodied experience of a subject who is embedded into a certain environment and has certain relationships.[37]

The different ways we use to talk about a condition reveal the perspective we are inclined to hold. In the first two cases, when we refer to an unhealthy condition with the words disease and sickness we are using a third-person perspective which tends to objectify both the person and her story, which is not only the story of her unhealthy condition. In contrast, when we use the word illness we are adopting a first-person perspective. The paradigm shift from a third-person, disease-centred perspective, into a first-person approach is not a linguistic quibble. Rather it reveals a great deal about how we describe and refer to a certain condition. Narratives from the first-person perspective puts into focus *how it is* to live with a mental health condition.[38] It is only around the early twentieth century, through the contribution of the first generation of psychiatrists – such as Jaspers, Binswanger, von Gebsattel, Minkowski and Straus, just to name a few – who introduced the phenomenological method to mental health, that first-person accounts of illness started to be the basis for better description and understanding of lived phenomena. A central dimension of the phenomenological analysis is the reality and relevance of the given and lived experiences. The aim of this analysis is not to account for how a physical world gives rise to a first-person perspective, but rather to consider how phenomena, including the objective world, emerge from the first-person perspective.[39] In order to reach this goal, the development of innovative tools, such as semi-structured phenomenological[40] and the micro-phenomenological interviews,[41] is significant to grasp the disturbances in the relationship between the self and the world, to

[36] See Boyd K. M., (2000). "Disease, illness, sickness, health, healing and wholeness: exploring some elusive concepts". In *Journal of Medical Ethics: Medical Humanities*, 26, pp. 9–17.

[37] See Svenaeus, F. (2018). "Human Suffering and Psychiatric Diagnosis". In *Bioethica Forum*, 11, 1, pp. 4–10

[38] At the beginning of nineteenth century first-person accounts of illness, particularly mental illness, were rare. Here I would like to briefly recall some fundamental books on this topic: Schreber, D. P. (2000) *Memoirs of My Nervous Illness* (original 1903). New York: New York Review of Books; Sacks, E. R. (2008) *The Center Cannot Hold: My Journey Through Madness*. New York: Hachette Books; Brampton, S. (2009) Shoot the Damn Dog: A Memoir of Depression. London: Bloomsbury Publishing; Sechehaye, M., (2011). Autobiography Of A Schizophrenic Girl: Reality Lost And Regained. Whitefish: Literary Licensing.

[39] See Parnas, J. (2000). "The self and intentionality in the pre-psychotic stages of schizophrenia: A phenomenological study", in D. Zahavi (ed.), *Exploring the Self. Philosophical and psychopathological perspectives on self-experience*. Amsterdam: John Benjamins Publishing Company, pp. 115–147.

[40] See the EASE (2005) and the EAWE (2017) interviews.

[41] See Petitmengin, C., Remillieux, A., Valenzuela-Moguillansky C. (2018). "Discovering the structures of lived experience. Towards a micro-phenomenological analysis method". In *Phenomenology and the Cognitive Sciences* (4) 691-730; Depraz, Natalie, Desmidt T. (2019). "Cardiophenomenology: a refinement of neurophenomenology". In *Phenomenology and the Cognitive Sciences*, 18, pp. 493–507.

help patients to review their experiences,[42] and to cast light on the mind-brain problems.[43]

Taking first-person reports and personal stories seriously is a challenge because it can trigger the recounting and describing of the experiences through elements which may falsify the content of the experience. Since descriptions and first-person accounts of illness are grounded in a self-narrative, the mineness of the experience[44] must be rigorously described in phenomenological terms in order to ensure validity. However, a first-person approach can illustrate how validity need not be considered in terms of representative exactness, but rather in terms of authenticity and performative consistency.[45] In the context of first-person reports, validity cannot be assessed according to its ability to reproduce the described content, but according to the *quality* of its own production process: "We are witnessing the emergence of a new conception of the validity of a description, which cannot be measured in static terms of correspondence to experience, but in dynamic terms of authenticity of the process of becoming aware and describing. (. . .) The validity of a description is not evaluated by comparing it with its hypothetical 'object', but according to the authenticity of the process that generated it".[46] In other words, the validity of a first-person report is a *validity 'in action'*, which cannot be measured in static terms of correspondence between the report and the experience, but in dynamic terms of performative consistency of the acts which produce it.[47]

A diagnosis of a mental disorder tells us something about a disease in very technical language, and as such it has clinical meaning but, at the same time, it does not say so much in terms of existential meaning. The issue of personal suffering is often not taken into consideration. The chasm between these two different yet entangled issues can lead to a loss of meaning in life, which, as consequence, can affect an already vulnerable condition. In this fissure lays the philosophical dilemma of the relationship between science and truth. Since the end of the seventeenth century, science has built a paradigm of truth in terms of measurability, calculations, and projections: only what can be proven through numbers is effective and, as such,

[42] See Høffding, S., Martiny, K. M. (2015). "Framing a Phenomenological Interview: What, Why and How". In *Phenomenology and Cognitive Sciences*, 4, pp. 539–564; Lauterbach, A. (2018). "Hermeneutic Phenomenological Interviewing: Going Beyond Semi-Structured Formats to Help Participants Revisit Experience". In *The Qualitative Report,* 23 (11), pp. 2883–2898.

[43] See Wagemann J., Edelhäuser F., Weger U. (2018). "Outer and Inner Dimensions of Brain and Consciousness—Refining and Integrating the Phenomenal Layers". In *Advances in Cognitive Psychology* 14(4), pp. 167–185.

[44] See Zahavi D. (2014). *Self and Other: Exploring Subjectivity, Empathy, and Shame*. Oxford: Oxford University Press.

[45] See Petitmengin C., Bitbol M. (2009). "The Validity of First-Person Descriptions as Authenticity and Coherence". In *Journal of Consciousness Studies*, 11–12, pp. 363–404.

[46] Petitmengin C., Bitbol M. (2009). "The Validity of First-Person Descriptions as Authenticity and Coherence", pp. 389-390.

[47] Petitmengin C., Bitbol M. (2009). "The Validity of First-Person Descriptions as Authenticity and Coherence", p. 400.

true. But *exactness is not truth*. Truth includes many factors which are not taken into account in the scientific process grounded in the Galilean criterion of validity. For better or for worse, Martin Heidegger put this argument in the starkest terms by attacking the very basis of the objectification processes in which science, as well as Western metaphysics, are summoned since they restrict the understanding of humans (as well as of the world around us) within narrow boundaries: "In today's science we find the desire to have nature at one's disposal, to make it useful, to be able to calculate it in advance, to predetermine how the process of nature occurs so that I can relate to it safely. Safety and certainty are important. There is a claim for certainty in having nature at one's disposal. That which can be calculated in advance and that which is measurable—only that is real".[48] The process of objectification is not confined to the scientific understanding of nature, rather it also concerns human beings (and non human beings), which are regarded under the "principle of quantity". It is through this metaphysical and epistemological standpoint that exactness (not truth) is of service to meaning. But *meaning is not about exactness*, rather it is related with one's own *experience of the world*.

Receiving a diagnosis of mental illness can often give rise to feelings of meaninglessness and despair through which the personal identity is shaken in its totality. For patients, the experience of illness in general, and mental health issues in particular, can be a radical interrogation about who they really are, what their lives are about, and what genuinely matters in their existence. By attacking the integrity of the self, illness makes it difficult and sometimes impossible to grasp the initiatives which underlie the work of interpretation and thereby the very process of the construction of meaning is jeopardised. If it is true that illness can be an occasion to both scrutinise the meaning of one's life and to explore new meanings, it is also true that it can disturb the meaning-making processes. This is why a non-reductionist approach to mental health is central to the recovery process and necessary for allowing the individual to regain a sense of meaning in life. In this sense, it should be vital for clinicians to overcome the idea of fixing something broken in people and dismantle the idea that the role of the person is peripheral, as a passive victim of a disease to be fixed. The person is fundamental in the healing journey; she is a goal-directed being, her feelings, interpretations, and actions are helpful to drive the phases of disorder and improvement. "We in the mental health field do not listen to what patients experience as well as we think. There are many things that patients are trying to tell us about their subjective experiences that we systematically fail to hear. This greatly limits the accuracy and value of current descriptive psychiatry".[49] Clinicians often discount patients' stories and experience in light of the tendency to quickly translate into biological or psychological explanations that which cannot be reduced to these factors: "One common aspect of this problem is our inadequate attention to learning about and understanding patients' competence, skills, and

[48] Heidegger M. (2001). *Zollikon Seminars*, Evanston: Northwestern University Press, p. 19.

[49] Strauss J. S. (1989). "Subjective experiences of schizophrenia: toward a new dynamic psychiatry. II". In *Schizophrenic Bulletin*, 15, p. 179.

other features of psychological health".[50] This tendency is what often blocks the possibility of an authentic encounter between patients and clinicians. In his late work entitled *The Enigma of Health,* Hans Georg Gadamer points out that health is not something that can simply be made or produced by doctors. Rather in all medical treatment "the patient needs to receive guidance, and here the discussion and shared dialogue between doctor and patient plays a decisive role".[51] In medical science when the individual patient is objectified in terms of a mere multiplicity of data, "all the information about a person are treated as if they could be adequately collated on a card index. If this is done correctly, then the relevant data will all uniquely apply to the person involved. But the question is whether the unique value of the individual is properly recognized in this process".[52]

16.5 The Words We Need, the World We Shape

Words are considered among the first 'tools' human beings use. They are born as sounds, imperfect and repetitive sounds that toddlers pronounce and gradually, in accordance with their cognitive development, they become proper words. "We speak because speaking is natural to us",[53] says Martin Heidegger. Speaking does not arise out of some special volition: "Man is said to have language by nature. It is held that man, in distinction from plant and animal, is the living being capable of speech".[54] Words and language are the precious elements upon which culture, in particular Western culture, is grounded. The very simplified passage from mythos to logos, often quoted as the moment of transition from knowledge to reasoning and considered as the occasion for the birth of philosophy between the VII and VI centuries BC, says something about the importance of words for Western civilisation: logos means not only 'reason' but also 'word', 'speech', 'discourse', and perhaps this is one reason among many others why rhetoric, the art of using words effectively, was so important in education in ancient times. We cannot imagine the Greek old literature, for example, without words, nor Shakespeare's plays. We cannot imagine an important part of opera without words, and the same goes for our ordinary lives and the common gestures each of us perform when we ask very simple questions or pass on information. Words are fundamental elements

[50] Strauss J. S. (1989). "Subjective experiences of schizophrenia: toward a new dynamic psychiatry. II", p. 180.

[51] Gadamer H-G. (1996). *The enigma of health. The Art of Healing in a Scientific Age*. Cambridge: Polity Press, p. 77.

[52] Gadamer H-G. (1996). *The enigma of health. The Art of Healing in a Scientific Age*, p. 81.

[53] Heidegger, Martin. (1971). *Poetry – Language – Thought*. New York: HarperCollins Publishers, p. 187.

[54] Heidegger, Martin. (1971), *Poetry – Language – Thought*, p. 187.

in our way of talking, communicating, exchanging information, and getting into relationships, *but* they are not confined to this.

Philosophically speaking, words are not things *strictu sensu,* nor are they merely tools. The tendency to represent words according to the common principle of their use is a habit rooted in our culture that does not highlight sufficiently how words are windows into the world. The ability of words to signify things is a consequence of their more foundational ability *to unveil* relationships and behaviours. These are the results of linguistic patterns. Our original ability to speak and to listen is what brings us into dialogue: *being a dialogue* is not simply a verbal exchange of information, or a conversation, or a discussion, but rather it is an experience that reminds us of the openness of our constitution. "Dialogue *is* what we are",[55] writes Gadamer. Through dialogue we encounter alterity[56] and we have an experience of our transcendence.

The famous dictum of Ludwig Wittgenstein, "the limits of my language mean the limits of my world"[57] addresses the relationship between our ability to use language and to provide meaning. But, if we want to make a step further, we can say that this sentence can also show the link between our behaviours and relationships with language. The limits of language and world are a kind of mirror of how we think, how we act, and how we express emotions. Put differently, words unveil our relationship with alterity, regardless of whether this 'other' is a person, an object, a non-human being, or the world in general. Words *found (Stiften)* the world, says Heidegger: "Founding as bestowing, founding as grounding, and founding as beginning".[58] In their original founding activity, words disclose the world for the human ability of "dwelling" in the world,[59] which means not merely to live in the world, but also to protect it and cherish it, shaping also the meaning we aim to provide it. The path from words to worlds relates precisely to this: what kind of world – not merely physical, as *Umwelt* – we are able to dwell in, to recognise, to protect, and to take care of. Perhaps now it is clear why words are more than means of information; they contribute to the formation of an identity (personal and collective), they carry values, they encourage practices and nourish social emotions.

Similarly, metaphors play a cardinal role in everyday life, "not just in language but in thought and action. Our ordinary conceptual system, in terms of which we both think and act, is fundamentally metaphorical in nature".[60] Metaphors are not merely confined to poetical language, but rather they inform our conceptual system and shape it accordingly. They possess and manifest a certain coherence with our culture and its values. These are some reasons why the role of metaphors and language is fundamental in the context of mental health. In the field of medicine,

[55] Gadamer, H.G. (1996). *The Enigma of Health*, p. 166.

[56] See Stanghellini, G. (2017). *Lost in dialogue,* Oxford University Press, Oxford.

[57] Wittgenstein, L. (2000). *Tractatus Logico-Philosophicus*. London-New York: Routledge, p. 68.

[58] Heidegger, Martin. (1971), p. 72.

[59] Heidegger, Martin. (1971), p. 145.

[60] Lakoff, G., Johnson, M. (1980/2008). *Metaphors We Live By*. Chicago: Chicago University Press, p. 4.

language is not only a very technical tool to convey information between doctors and patients; it is also a powerful resource to enforce stigma, to reduce the ability to cope with a disease and to build a social narrative which is often unhelpful for society at many levels.[61] For example, the war narrative and war jargon in the context of the current COVID-19 pandemic,[62] or the war metaphors used with reference to oncological patients are completely counterproductive. It is common to speak about doctors fighting for their patients' lives or fighting a disease. Yet, these narratives are wrong because they are unhelpful. For people with cancer for example, it was found that such narratives increase perceptions of difficulty, which could negatively affect the health beliefs of non-patients.[63]

We do not simply use metaphors and narratives to recount our personal story as well as the story of our illness, but rather *we embody them*. Bodily metaphors arise out of the embodied nature of our emotions, which are also shaped by language conventions. Language and metaphors evoke physical sensations both in our body and in our mind, showing those pathways upon which to build our memory.[64] The words we choose can thus dramatically impact people's perceptions in ways that have cognitive, behavioural and physical consequences and may reinforce cultural stereotypes and stigmas. The language of a diagnosis may lead to the consolidation of a stigma in and around the person who receives the examination. In fact, on one hand, if diagnosis is an important tool used by clinicians to convey clinical information, on the other hand it is also a label that accompanies a patient through their life (to some extent, or in some cases for the rest of her life) and in many cases it interferes with interpersonal relationships, professional career, social exchanges and also affective life. The habit of using the label of a diagnosis just to denote someone is a sign of how powerful a diagnosis can be, also in the depersonalisation. The risk of being deprived of one's own story and identity in order to assume the name of the diagnosis is a stigma, reinforced by many cultural and social stereotypes. The relationship between public stigma and self-stigma is circular and reciprocal, and it passes also through language increasing the awareness of "diversity" (the so-called differentiating mark) and causing insecurity, anxiety and fear. Despite progress in evidence-based treatments, and increasing public knowledge about mental disorders, people who receive a diagnosis of mental illness still report a direct experience of stigma and discrimination. Social emotions, as well as public beliefs, impact the perceptions of people with addictions or disabilities: labelling,

[61] See Sontag, S. (1978). *Illness as Metaphor*. New York: Farrar Straus & Giroux Publ. House.

[62] See Brencio, F. (2020). "Mind your words. Language and war metaphors in the COVID-19 pandemic". In *Psicopatologia Fenomenológica Contemporânea. Revista da Sociedade Brasileira de Psicopatologia Fenômeno-Estrutural*, 9(2), pp. 58–73, doi: https://doi.org/10.37067/rpfc.v9i2.1083.

[63] Hauser, D. J. & Schwarz, N. (2019). "The War on Prevention II: Battle Metaphors Undermine Cancer Treatment and Prevention and Do Not Increase Vigilance". In *Health Communication*, pp. 1–7, doi: https://doi.org/10.1080/10410236.2019.1663465.

[64] Koch, S., Fuchs, T., Summa, M. (2012). *Body Memory, Metaphor and Movement*. Amsterdam/Philadelphia: John Benjamins Publishing Company.

stereotyping and separation are common in these cases and are powerful experiences which negatively transform people's lives. Emotional suffering, social isolation, breakdown of career and the slide toward a poor quality of life are the first signs of the magnitude of stigma in every context.

For these reasons, the description and understanding of mental health issues might be the proper occasion for reassessing roles and models in clinical practices, focusing on a more careful attention to a person-centred approach. These elements are cardinal in view of a more "humanistic psychiatry", not locked up in its narrow biomedical and naturalistic view, but rather inspired by a deep and (at the same time) fragile commonality with human sciences. The 'psychiatric object' is not confined to a symptom, not to an inferred brain disease, never to an object. It is a subject, in its vulnerable and yet resilient ability *to be human*.

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